

HGOV4100

Fundamentals of Health Care Systems

Autumn 2019

Guidelines for sensors

The final exam consisted of two parts, A and B. Part A had three questions to answer. In Part B, two short essay questions were asked and one of these questions was asked to be selected and answered. Grades are based 70% (max grade 70) on questions in Part A and 30% (max grade 30) based on questions in Part B.

Grading:

0-49p = F

50-59p = E

60-69p = D

70-79p = C

80-89p = B

90-100p = A

Median Score : B

Part A Short Answers

- 1- When the Diagnosis Related Group (DRG) payment method is put into effect in a health care system as one of the methods of reimbursement scheme, what weaknesses/difficulties would you encounter in using DRG as a method of reimbursement as a health care administrator? (20 Marks/Points)

In answering this question, it is expected that the following issues should be addressed: definition of DRG, incentive to increase the number of patients hospitalized, DRG creep, complexity of coding, cream-skimming, transfer of hospitalized patients to other hospitals, discharging patients prematurely.

- With a fixed payment per case, hospitals retain an incentive to increase the number of patients hospitalized, even when outpatient management is acceptable or preferred.
- Hospitals benefit from increasing revenues per patient, most easily achieved by changing coding practices of diagnoses and procedures (“DRG creep”) or by providing services that lead to reclassification of patients into higher-paying DRGs.

- In comparison to other methods for paying hospitals, DRGs are more complex, requiring coding expertise, data systems, and active oversight of coding by payers.
- In commonly used DRG designs, performing a surgical procedure produces a substantially higher payment net of cost for the same diagnosis without a procedure. Thereby, clinical decision-making is potentially skewed to favor procedures when medical management might suffice.
- Hospitals have an incentive to select profitable, low-cost patients (“cream-skimming”) in each DRG and transfer or avoid unprofitable, higher-cost patients.
- Hospitals may discharge prematurely, compromising quality yet rewarding hospitals if the patients are readmitted (unless the DRG design does not permit a new payment for readmission within a specified time period, e.g., 30 days).
- Hospitals may transfer patients to other hospitals or postacute care facilities, generating overpayments from the artificially low length of stay.

2- Explain the dimensions of health performance measures in a health system. (25 Marks/Points)

In answering this question, it is expected that the following issues should be addressed, and some examples related to dimensions should be given: description of performance measurement in health, population health, individual health outcomes, clinical quality and appropriateness of care, responsiveness of health system, equity, productivity.

- Population health: Measures of aggregated data on the health of the population. Examples: Life expectancy Years of life lost Avoidable mortality, Disability-adjusted life-years
- Individual health outcomes: Measures of individual’s health status, which can be relative to the whole population or among groups. Indicators that also apply utility rankings to different health states. Examples: Generic measures: Short form 36 (SF-36), EQ-5Db
Disease-specific measures: arthritis impact measurement scale, Parkinson’s disease questionnaire (PDQ-39)
- Clinical quality and appropriateness of care: Measures of the services and care patients receive to achieve desired outcomes. Measures used to determine if best practice takes place and whether these actions are carried out in a technologically sound manner Examples: Outcome measures: health status, specific post-operative readmission and mortality rates. Process measures: frequency of blood pressure measurement
- Responsiveness of health system: Measures of the way individuals are treated and the environment in which they are treated during health system interactions. Measures concerned with issues of patient dignity, autonomy, confidentiality, communication, prompt attention, social support and quality of basic amenities. Examples: Patient experience measures Patient satisfaction measures
- Equity: Measures of the extent to which there is equity in health, access to health care, responsiveness and financing. Examples: Utilization measures Rates of access Use-needs ratios, spending thresholds, disaggregated health outcome measures

- Productivity: Measures of the productivity of the health care system, health care organizations and individual practitioners: Examples: Labour productivity, Cost-effectiveness measures (for interventions), Technical efficiency (measures of output/input), Allocative efficiency (measured by willingness to pay)

3- Define the health systems by using “OECD typology of health systems”? (25 Marks/Points)

In answering this question, it is expected that the following issues should be addressed: private insurance model, social insurance model (Bismarck model), tax based model (national health system or Beveridge model), country examples

- Private Insurance Model: The private insurance (or consumer sovereignty) model has the least state involvement in the direct funding or provision of health care services. This model is distinguished by the purchase of private health insurance financed by employers and/or individual contributions that are risk oriented. This system is also largely based on private ownership of health care providers and the components of production, although it might include a publicly funded safety net for the most vulnerable groups such as the poor, the elderly or children. The principal premise of this approach is that the funding and provision of health care is best left to market forces.
- Social Insurance Model: This model is based on a concept of social solidarity and characterized by a universal coverage health insurance generally within a framework of social security. As a rule, this insurance is compulsory and funded by a combination of employer and individual contributions through non-profit insurance funds or societies, often regulated and subsidized by the state. The provision of services tends to be private, often on a fee-for-service basis, although some public ownership of the factors of production and delivery is common.
- Tax Based Model: This model is characterized by universal coverage funded out of general taxation. The provision of health care services under this model is fully administered by the state, which either owns or controls the factors of production and delivery.

Part B Short Essay

1- Do you think the universal mandatory health insurance in the Netherlands can be a health insurance model for the United States? (30 Marks/Points)

In answering this question, it is expected that the following issues should be addressed: general characteristics of the Dutch health system, general characteristics of the US

health system, mandatory universal health insurance, competition among private health insurers, managed care, cost containment, supply-side regulations, universal access, consumer choice of insurers, integrated health delivery systems, student's views on whether the Dutch model can be used for the United States.

or

- 2- What do you think about the implementation of Obama Care (Patient Protection and Affordable Care Act) in the US health system (Patient Protection and Affordable Care Act)? (30 Marks/Points)

In answering this question, it is expected that the following issues should be addressed: need for ACA, basic principles, public sector arrangements (Medicare, Medicaid), reforms in the market for private insurance, denial of coverage, denial of claims based on pre-existing conditions, basic benefit package, subsidies to individuals and firms and develop marketplaces, expanding Medicaid eligibility, funding of the system (spendings through Medicare, impact on reimbursements, increased taxes), future directions, student's views on ACA.